

2006 KAISER PERMANENTE MEDICARE PLUS

SUMMARY OF BENEFITS FOR PLAN C

Introduction to the Summary of Benefits
DC, MD, VA

Thank you for your interest in Kaiser Permanente Medicare Plus. The staff and physicians of Kaiser Permanente look forward to being a partner in your good health. We know that being as healthy as possible and feeling great gives you the ability to live life to the fullest.

Our plan is offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., a Medicare Cost Managed Care plan. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage."

You have choices in your health care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Kaiser Permanente Medicare Plus. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may be able to join or leave a plan only at certain times. Please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. at the number listed at the end of this introduction or

1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048.

How can I compare my options?

You can compare the Kaiser Permanente Medicare Plus plan and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer additional benefits, which may change from year to year.

Where is the Kaiser Permanente Medicare Plus plan available?

The Service Area for this plan includes:

District of Columbia

Maryland: The service area for this plan includes the following cities and counties: Anne Arundel, Baltimore City, Baltimore, Calvert* (partial), Carroll, Charles* (partial), Frederick* (partial), Harford, Howard, Montgomery, and Prince George's.

- * Calvert is a partial county consisting of the following zip codes:
20639, 20678, 20689, 20714, 20732, 20736, 20754.
- * Charles is a partial county consisting of the following zip codes:
20601, 20602, 20603, 20604, 20612, 20616, 20617, 20637, 20640,
20643, 20646, 20658, 20675, 20677, and 20695.
- * Frederick is a partial county consisting of the following zip codes:
21701, 21702, 21703, 21704, 21705, 21709, 21710, 21714, 21716,
21717, 21718, 21754, 21755, 21758, 21759, 21762, 21769, 21770,
21771, 21774, 21775, 21777, 21790, 21792, 21793.

Virginia: The service area for this plan includes the following cities and counties: Alexandria City, Arlington, Fairfax City, Fairfax, Falls Church City, Loudoun, Manassas City, Manassas Park City, and Prince William.

You must live in one of these places to join and have continued membership in the plan.

Can I choose my doctors?

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. has formed a network of doctors, specialists, and hospitals. You can use any doctors who are part of our Kaiser Permanente Medicare Plus network. You may also go to doctors who are outside of our network. The health providers in our network can change at any time. You can ask for a current Physician Directory or locate it on our Web site, kaiserpermanente.org. Our number is listed at the end of this introduction.

What happens if I go to a doctor who's not in your network?

You can always choose to go to a doctor outside our Medicare Plus network. We may not pay for the services you receive outside of our network. You may have to pay more for the services you receive outside the Medicare Plus network. If you go to a provider outside of Kaiser Permanente Medicare Plus who accepts Medicare patients, your coverage will be the same as Original Medicare. Original Medicare deductibles and coinsurance apply and will be your responsibility to pay.

Where can I get my prescriptions if I join this plan?

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. has formed a network of pharmacies. You can use any pharmacy in the Medicare Plus network. The pharmacies in the Medicare Plus network can change at any time. You can ask for a current Pharmacy Directory that includes a list of Medicare Plus network pharmacies or locate it on our website at kaiserpermanente.org. Our number is listed at the end of this introduction.

What happens if I go to a pharmacy that's not in your network?

If you go to a pharmacy that's not in the Medicare Plus network, you might have to pay more for your prescriptions. You also might have to follow special rules before getting your prescription in order for the prescription to be covered under our plan. For more information, call the telephone number at the end of this introduction.

Does my plan cover Medicare Part B or Part D drugs?

This Medicare Plus plan covers Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Does my plan have a prescription drug formulary?

Medicare Plus uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs. Medicare Plus may periodically make changes to the formulary. If the formulary changes, affected enrollees will be notified in writing before the change is made. Contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. for more details.

What is a Medication Therapy Management (MTM) program?

A medication therapy management (MTM) program is a benefit that your plan may offer. You may be identified to participate in a program designed for your specific health and pharmacy needs. It is recommended that you take full advantage of this covered benefit if you are selected. Contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. for more details.

What types of drugs may be covered under Medicare Part B?

The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision
- **Osteoporosis Drugs:** : Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin alpha or Epogen):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and Infusion drugs** provided through DME.
- **Intravenous Immune Globulin (IVIG)** for treatment of primary immune deficiency diseases received in the home.

What should I do if I have other insurance in addition to Medicare?

If you have Medicare supplemental insurance that fills gaps in the Original Medicare Plan, you may not need it if you join Kaiser Permanente Medicare Plus. If you drop your supplemental policy, you may not be able to get the same one back. You should check into this carefully before you drop your supplemental policy to make sure you have all of the coverage you need.

You or your spouse may have, or be able to get, employer group health coverage. If so, you should talk to the employer to find out how your benefits will be affected if you join Kaiser Permanente Medicare Plus. Get this information before you decide.

What are my protections in this plan?

All health plans in the Medicare program agree to stay with the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare managed care plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for health care coverage in your area and give you information about your right to get Medicare supplemental insurance coverage. You can choose another health plan if one is available, or you can receive care from the Original Medicare Plan.

If Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ever denies your claim or a service, we will explain our decision to you. You always have the right to appeal and ask us to review the claim or service that was denied. If a decision is not made in your favor, your appeal will be reviewed by an independent organization that works for Medicare.

Please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. for more information about this plan. Visit us at kaiserpermanente.org. Current and prospective members can also call Member Services, Monday through Friday, 7:30 a.m. to 5:30 p.m. on 301-468-6000 or 1-800-777-7902 outside the Washington D.C. metropolitan area or 301-879-6380 (TTY). Please call Medicare at 1-800-633-4227 or visit www.medicare.gov for more information about Medicare. (TTY/TDD # 1-877-486-2048). If you have special needs, this document may be available in other formats.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/06); or KFHP-MDCOST-EOC (01/06); or KFHP-VACOST-EOC (01/06)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

Kaiser Permanente Medicare Plus	Original Medicare
<p>1 – Doctor and hospital choice (For more information, see Emergency care - #8, and Urgently needed care - #9.)</p> <p><u>In Network:</u> You must go to network doctors, specialists, and hospitals.</p> <p>You need a referral to go to Kaiser Permanente network hospitals and certain doctors, including specialists for certain services.</p> <p>A Visitor/Travel program is available.</p> <p><u>Out-of-Network if you have both Medicare Parts A&B:</u> If you go to a provider outside of Kaiser Permanente Medicare Plus who accepts Medicare patients, your coverage will be the same as Original Medicare. Original Medicare deductibles and coinsurance apply and will be your responsibility to pay.</p> <p><u>Out-of-Network if you have Medicare Part B Only:</u> If you receive Medicare-covered Part B services from a provider outside of Kaiser Permanente Medicare Plus who accepts Medicare patients, your coverage will be the same as Original Medicare Part B. Original Medicare Part B deductibles and coinsurance apply and will be your responsibility to pay.</p>	
<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	

2 - Inpatient hospital care (Includes substance abuse and rehabilitation services)

You pay nothing benefit period⁽³⁾ for a Medicare-covered stay in a network hospital.⁽⁵⁾

There is no copayment for additional days received in a network hospital.

You are covered for unlimited days each benefit period.⁽³⁾

Except in an emergency, your provider must obtain authorization from Kaiser Permanente Medicare Plus.

If you have both Medicare Parts A&B:

You pay for each benefit period⁽³⁾:

Days 1-60: an initial deductible of \$952

Days 61-90: \$238 each day

Days 91-150: \$476 each lifetime reserve day⁽⁴⁾

Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.⁽⁴⁾

If you have Medicare Part B Only:

In general, you pay 100%.

3 - Doctor office visits

You pay \$5 for each primary care doctor office visit for Medicare-covered services.

You pay \$5 for each specialist visit for Medicare-covered services.⁽⁵⁾

See #32– Physical exams for more information.

You pay 20% of Medicare-approved amounts.⁽¹⁾⁽²⁾

(1) Each year, you pay a total of one \$124 deductible.

(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/Utilization Review.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/06); or KFHP-MDCOST-EOC (01/06); or KFHP-VACOST-EOC (01/06)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

Kaiser Permanente Medicare Plus	Original Medicare
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4 - Diagnostic tests, x-rays and lab services

There is no copayment for the following Medicare-covered services:

- X-ray visits⁽⁵⁾
- Clinical diagnostic lab service⁽⁵⁾

You pay \$5 per visit for each Medicare-covered radiation therapy service.⁽⁵⁾

You pay 20% of Medicare-approved amounts, except for approved lab services.⁽¹⁾⁽²⁾

There is no copayment for Medicare-approved lab services.

5 - Part B Medicare-covered drugs Drugs that are covered by Original Medicare Part B do not count toward your Medicare Prescription Drug (Part D) total out-of-pocket expenditure. (That is, the amount you pay does not help you obtain catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not receive any extra help to pay for these Part B prescriptions.

There is no annual maximum benefit limit on Part B Medicare-covered drugs.

Kaiser Permanente Mail Delivery Service:

For up to a 60-day supply you pay:

- Generic or Brand: \$3

Kaiser Permanente Medical Center Pharmacy:

For up to a 60-day supply you pay:

- Generic or Brand: \$5

Kaiser Permanente Affiliated Network Pharmacy:

For up to a 60-day supply you pay:

- Generic or Brand: \$10

You pay 20% of Medicare-approved amounts.⁽¹⁾⁽²⁾

6 - Part D outpatient prescription drugs

This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified in writing, before the change. To view the plan's formulary, go to kaiserpermanente.org on the web.

People who have low incomes, who live in long-term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact the plan for details.

There is no deductible.

Before your yearly out-of-pocket drug costs reach \$3,600, you pay:

Kaiser Permanente Mail Delivery Service:

For up to a 60-day supply you pay:

- Generic or Brand: \$3

Kaiser Permanente Medical Center Pharmacy:

For up to a 60-day supply you pay:

- Generic or Brand: \$5

Kaiser Permanente Affiliated Network Pharmacy:

For up to a 60-day supply you pay:

- Generic or Brand: \$10

Out-of-Network Pharmacy*:

For up to a 30-day supply you pay:

- Generic or Brand: \$5

You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug Program

- (1) Each year, you pay a total of one \$124 deductible.
- (2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.
- (3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.
- (4) Lifetime reserve days can only be used once.
- (5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/Utilization Review.

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Kaiser Permanente Medicare Plus	Original Medicare
<p>6 - Part D outpatient prescription drugs - cont.</p> <p>After your yearly out-of-pocket drug costs reach \$3,600, you pay the following for prescription drugs</p> <p><u>At any Kaiser Permanente Mail Delivery, Medical Center or Affiliated Network Pharmacy:</u></p> <ul style="list-style-type: none"> • Generic: \$1 • Brand: \$2.50 <p><u>Out-of-Network Pharmacy*:</u></p> <ul style="list-style-type: none"> • Generic: \$1 • Brand: \$2.50 <p>Certain prescription drugs will have maximum quantity limits.</p> <p>*Note: We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to the paper claims process described in the Evidence of Coverage. You will be responsible for paying applicable cost-shares and all amounts over and above the amount Kaiser Permanente would have paid to an in-network non-preferred pharmacy (Kaiser Permanente Affiliated Network Pharmacy).</p>	

7 – Ambulance services (Medically necessary ambulance services)

You pay nothing for Medicare-covered ambulance services.

You pay 20% of Medicare-approved amounts or applicable fee schedule charge.⁽¹⁾⁽²⁾

8 – Emergency care (You may go to any emergency room if you reasonably believe you need emergency care.)

You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital within 48 hour(s) for the same condition.

Worldwide coverage.

You pay 20% of the facility charge or applicable copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.⁽¹⁾⁽²⁾

You pay 20% of doctor charges.⁽¹⁾⁽²⁾

NOT covered outside the U.S. except under limited circumstances.

9 - Urgently needed care (This is NOT emergency care, and in most cases, is out of the service area.)

You pay \$5 for each Medicare-covered urgently needed care visit.

Worldwide coverage.

You pay 20% of Medicare-approved amounts or applicable copayment.⁽¹⁾⁽²⁾

NOT covered outside the U.S. except under limited circumstances.

(1) Each year, you pay a total of one \$124 deductible.

(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/Utilization Review.

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Kaiser Permanente Medicare Plus	Original Medicare
10 - Ambulatory surgical services and outpatient hospital services	
You pay nothing for each Medicare-covered visit to an ambulatory surgical center. ⁽⁵⁾	You pay 20% of Medicare-approved amounts for the doctor. ⁽¹⁾⁽²⁾
You pay nothing for each Medicare-covered visit to an outpatient hospital facility. ⁽⁵⁾	You pay 20% of outpatient facility charges. ⁽¹⁾⁽²⁾
Authorization rules may apply for services. Contact plan for details.	
11 - Durable medical equipment (Includes wheelchairs, oxygen, etc.)	
You pay nothing for each Medicare-covered item. ⁽⁵⁾	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾
Authorization rules may apply for services. Contact plan for details.	
12 - Prosthetic devices (Includes braces, artificial limbs and eyes, etc.)	
You pay nothing for each Medicare-covered item. ⁽⁵⁾	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾

13 - Dental services

You pay \$30 for an office visit that includes the following services:

- Oral exams up to 1 visit every six months
- Cleanings up to 1 visit every six months
- Fluoride treatment up to 1 visit every six months
- Dental x-rays up to 1 visit every six months

Additional benefits are available.⁽⁵⁾

In general, you pay 100% for dental services.

14 - Vision services

You pay:

- all charges above the Medicare-approved amount for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery).⁽⁵⁾
- \$5 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).
- \$5 for each routine eye exam
- 75% of the cost for glasses
- 85% of the cost for contacts.

You are covered for one pair of eyeglasses or contact lenses after each cataract surgery.⁽¹⁾⁽²⁾

For people with Medicare who are at risk, you are covered for annual glaucoma screenings.⁽¹⁾⁽²⁾

You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye.⁽¹⁾⁽²⁾

You pay 100% for routine eye exams and glasses.

(1) Each year, you pay a total of one \$124 deductible.

(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/Utilization Review.

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Kaiser Permanente Medicare Plus	Original Medicare
15 - Inpatient mental health care	
<p>You pay nothing per benefit period⁽³⁾ for a Medicare-covered stay in a network hospital.⁽⁵⁾</p> <p>Medicare beneficiaries may only receive 190 days in a psychiatric hospital in a lifetime.</p> <p>Except in emergency, your provider must obtain authorization from Kaiser Permanente Medicare Plus.</p>	<p><u>If you have both Medicare Parts A&B:</u> You pay for each benefit period⁽³⁾:</p> <p>Days 1-60: an initial deductible of \$952 Days 61-90: \$238 each day Days 91-150: \$476 each lifetime reserve day⁽⁴⁾</p> <p>Medicare beneficiaries may only receive 190 days in a psychiatric hospital in a lifetime.</p> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.⁽⁴⁾</p> <p><u>If you have Medicare Part B Only:</u> In general, you pay 100%.</p>

16 - Skilled nursing facility (In a Medicare-certified skilled nursing facility)

You pay nothing if Original Medicare would cover the stay.⁽⁵⁾

You pay nothing for a medically necessary admission if Original Medicare would not cover the stay.⁽⁵⁾

No prior hospital stay is required.

Note: Original Medicare will only cover skilled nursing facility care following a related 3-day hospitalization.

You are covered for 100 days each benefit period.⁽³⁾

Authorization rules may apply for services. Contact plan for details.

If you have both Medicare Parts A&B:

You pay for each benefit period⁽³⁾, following at least a 3-day covered hospital stay:

Days 1-20: \$0 for each day

Days 21-100: \$119 for each day

There is a limit of 100 days for each benefit period.⁽³⁾

If you have Medicare Part B Only:

In general, you pay 100%.

17 - Home health agency care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)

There is no copayment for Medicare-covered home health visits.⁽⁵⁾

Authorization rules may apply for services. Contact plan for details.

There is no copayment for all covered home health visits.

(1) Each year, you pay a total of one \$124 deductible.

(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

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Kaiser Permanente Medicare Plus	Original Medicare
18 - Hospice	
<p><u>If you have Medicare Parts A&B:</u> You must receive care from a Medicare-certified hospice.⁽⁵⁾</p> <p><u>If you have Medicare Part B Only:</u> You must receive care from a network hospice.⁽⁵⁾</p>	<p><u>If you have both Medicare Parts A&B:</u> You pay part of the cost for outpatient drugs and inpatient respite care and you must receive care from a Medicare-certified hospice.</p> <p><u>If you have Medicare Part B Only:</u> In general, you pay 100%.</p>
19 - Chiropractic services	
<p>You pay \$5 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).⁽⁵⁾</p>	<p>You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.</p> <p>You pay 100% for routine care.</p> <p>You pay 20% of Medicare-approved amounts.⁽¹⁾⁽²⁾</p>
20 - Podiatry services	
<p>You pay \$5 for each Medicare-covered visit (medically necessary foot care).⁽⁵⁾</p>	<p>You pay 20% of Medicare-approved amounts.⁽¹⁾⁽²⁾</p> <p>You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> <p>You pay 100% for routine care.</p>

Kaiser Permanente Medicare Plus	Original Medicare
21 - Outpatient mental health care	
For Medicare-covered mental health services, you pay \$5 for each individual/group therapy visit. ⁽⁵⁾	You pay 50% of the Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges. ⁽¹⁾⁽²⁾
Authorization rules may apply for services. Contact plan for details.	
22 - Outpatient substance abuse care	
For Medicare-covered services you pay \$5 for each individual/group visit. ⁽⁵⁾	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾
Except in emergency, your provider must obtain authorization from Kaiser Permanente Medicare Plus.	
23 - Outpatient rehabilitation services (Occupational therapy, physical therapy, speech and language therapy)	
You pay \$5 for each Medicare-covered occupational therapy visit. ⁽⁵⁾	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾
You pay \$5 for each Medicare-covered physical therapy and/or speech/language therapy visit. ⁽⁵⁾	
Authorization rules may apply for services. Contact plan for details.	

(1) Each year, you pay a total of one \$124 deductible.

(2) If your doctor or supplier chooses not to accept assignment, their costs are often higher, which means you pay more.

(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/Utilization Review.

This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and ask for the "Evidence of Coverage" (KFHP-DCCOST-EOC (01/06); or KFHP-MDCOST-EOC (01/06); or KFHP-VACOST-EOC (01/06)). If you have any questions about this plan's benefits or costs, please contact Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Monday through Friday from 7:30 a.m. until 5:30 p.m. at (301) 468-6000 or 1-800-777-7902 outside the Washington, DC metro calling area. People who have difficulty with hearing or speaking may call our TTY number, 301-879-6380. The TTY number requires special telephone equipment.

Kaiser Permanente Medicare Plus	Original Medicare
24 - Diabetes self-monitoring training and supplies (Includes coverage for glucose monitors, test strips, lancets, and Medicare-certified self-management training)	
You pay \$5 for Medicare-covered diabetes self-monitoring training. ⁽⁵⁾	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾
You pay nothing for each Medicare-covered diabetes supply item.	
25 - Bone mass measurement (For people with Medicare who are at risk)	
You pay \$5 for each Medicare-covered bone mass measurement. ⁽⁵⁾	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾
26 - Colorectal screening exams (For people 50+ with Medicare)	
You pay \$5 for each Medicare-covered colorectal screening exam. ⁽⁵⁾	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾
An additional facility charge may be included in the cost for services.	
27 - Immunizations (Flu vaccine, hepatitis B vaccine - for people with Medicare who are at risk, pneumonia vaccine)	
There is no copayment for the pneumonia and flu vaccines. Office visit copayment may apply.	There is no copayment for the pneumonia and flu vaccines.
No referral necessary for pneumonia and flu vaccines.	You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. ⁽¹⁾⁽²⁾
You pay \$5 for the hepatitis B vaccine. ⁽⁵⁾	You may only need the pneumonia vaccine once in your lifetime. Please contact your doctor for further details.

Kaiser Permanente Medicare Plus	Original Medicare
28 - Mammograms (annual screening) (For women 40+ with Medicare)	
You pay \$5 for each Medicare-covered screening mammogram. ⁽⁵⁾	You pay 20% of Medicare-approved amounts. ⁽²⁾ No referral necessary for Medicare-covered screenings.
No referral necessary for Medicare-covered screenings.	
29 - Pap smears and pelvic exams (For women with Medicare)	
You pay \$5 for each Medicare-covered pap smear and pelvic exam.	There is no copayment for a pap smear once every 2 years, annually for beneficiaries at high risk. ⁽²⁾
	You pay 20% of Medicare-approved amounts for pelvic exams. ⁽²⁾
30 - Prostate cancer screening exams (For men 50+ with Medicare)	
You pay \$5 for each Medicare-covered prostate cancer screening exam. ⁽⁵⁾	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services. ⁽²⁾
31 - Hearing services	
In general, you pay 100% for routine hearing exams and hearing aids. ⁽⁵⁾	You pay 100% for routine hearing exams and hearing aids.
You pay \$5 for each Medicare-covered hearing exam (diagnostic hearing exams). ⁽⁵⁾	You pay 20% of Medicare-approved amounts for diagnostic hearing exams. ⁽¹⁾⁽²⁾

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Kaiser Permanente Medicare Plus	Original Medicare
<p>32 - Physical exams</p> <p>If your coverage in Medicare Part B begins on or after January 1, 2005, you may receive a one-time physical exam within the first six months of your new Part B coverage.</p> <p>This will not include laboratory tests. Please contact your plan for further details.</p> <p>You pay \$5 for Medicare-covered services.⁽⁵⁾</p> <p>You pay \$5 for each exam.⁽⁵⁾</p> <p>You are covered up to 1 exam every year.</p>	<p>If your coverage in Medicare Part B begins on or after January 1, 2005, you may receive a one-time physical exam within the first six months of your new Part B coverage. This will not include laboratory tests. You pay 20% of the Medicare-approved amount.⁽¹⁾⁽²⁾</p>
<p>33 - Health/wellness education</p> <p>You are covered for the following:</p> <ul style="list-style-type: none"> • Health Ed classes • Newsletter • Nutritional training • Smoking cessation • Congestive heart program • Alternative medicine program • Nursing hotline • Disease management <p>Copayments may apply. Contact plan for details.</p>	<p>You pay 100%.</p>

Kaiser Permanente Medicare Plus	Original Medicare
34 – Outpatient kidney dialysis (within the service area)	
You pay nothing for Medicare-covered outpatient kidney dialysis at a Medicare-approved dialysis facility. ⁽⁵⁾	You pay 20% of Medicare-approved amounts. ⁽¹⁾⁽²⁾
You pay nothing for a Medicare-covered stay in a network hospital. ⁽⁵⁾	
You pay nothing per Medicare-covered visit to an outpatient hospital or ambulatory surgery center . ⁽⁵⁾	

(1) Each year, you pay a total of one \$124 deductible.

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(3) A benefit period begins the day you are admitted to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you are admitted to the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

(4) Lifetime reserve days can only be used once.

(5) Requires referral and/or authorization by Personal Physician or Organization Medical Director/Utilization Management/Utilization Review.

Exclusions

An "Exclusion" is an item or service that Kaiser Permanente Medicare Plus does not cover. You are responsible for paying for excluded items or services. **Any service (except for an emergency service or urgently needed service) that is not provided or arranged by a Plan Provider or not pre-authorized in advance may not be covered by Kaiser Permanente Medicare Plus.** If you go to a provider outside of Kaiser Permanente Medicare Plus who accepts Medicare patients, your coverage will be the same as Original Medicare. Original Medicare deductibles and coinsurance apply and will be your responsibility to pay.

In addition to any exclusions or limitations described in the Schedule of Medical Benefits within the Evidence of Coverage (EOC), the following items and services are limited or not covered by Kaiser Permanente Medicare Plus.

- Abortions, unless the life of the mother is endangered as the result of carrying the fetus to full term, and in the case of incest or rape.
- Alternative care including but not limited to acupuncture; biofeedback; chiropractic; naturopathic; and therapeutic massage therapy services and supplies; acupuncture & chiropractic except as described in the EOC.
- Charges imposed by immediate relatives or members of your household.
- Cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast reconstruction is covered when following a medically necessary mastectomy.
- Custodial Care, which includes care that helps members in the activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom; preparation of special diets; and supervision of medication that is usually self-administered.
- Dental Exclusions, Neither Health Plan nor Dental Benefit Providers (DBP) provides coverage for the following:
 1. Services of dentists or other practitioners of healing arts not associated with Health Plan and/or DBP except upon referral arranged by a Participating Dental Provider and authorized by us, or when required in a covered emergency. Such excluded services mean any kind of dental care and anything prescribed in connection therewith.
 2. Hospitalization for any dental procedure, except as may be otherwise covered in your medical plan which is described in the Evidence of Coverage.
 3. Any cosmetic, beautifying or elective procedure.
 4. Services of Pedodontists and/or Prosthodontists
 5. Experimental procedures, implantations, or pharmacological regimens.
 6. Drugs obtainable with or without a prescription, except as may be otherwise covered in your medical plan that is described in the Group Evidence of Coverage.
 7. Services for injuries or conditions which are covered under Workers' Compensation or Employer's Liability laws; services which are provided without cost to the Member by any municipality, county, or other political subdivision. This exclusion does not apply to any services that are covered by Medicaid.
 8. Placement of dental implants, implant-supported abutments and prostheses.
 9. Occlusal guards, except for the purpose of controlling habitual grinding.
 10. The setting of fractures or dislocations, except as may be otherwise covered in your medical plan which is described in the Group Evidence of Coverage.
 11. Treatment of malignancies, cysts or neoplasm or congenital malformations, except as may be otherwise covered in your medical plan which is described in the Group Evidence of Coverage.
 12. Replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
 13. Replacement of denture, bridgework and/or dental appliances previously supplied under the EOC, due to loss or theft, or for any reason within sixty (60) months of initial insertion.
 14. Services which, in the opinion of the attending Participating Dental Provider, are not necessary for the Member's dental health.
 15. Services pertaining, or related, to the Temporomandibular Joint (TMJ), except when those services are included on the attached dental fee schedule and are performed by the Member's Participating Dental Provider in that provider's office.
 16. Charges for failure to keep a scheduled dental appointment.
 17. Charges for second opinions, unless previously authorized by Health Plan.

18. Dental expenses incurred in connection with any dental procedure that was started prior to the Member's enrollment under the EOC. Examples include orthodontic work in progress, teeth prepared for crowns, and root canal therapy in progress.
19. Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
20. Procedures relating to the change and maintenance of vertical dimension or the restoration of occlusion.
21. Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Group Evidence of Coverage.
22. Procedures not shown on the attached dental fee schedule listing are not covered under the EOC.

Dental Limitations

- Clinical situations that can effectively be treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure, in accordance with the "Standards of Care" established by DBP for its participating providers.
- Additional limitations, such as how often we will cover a particular procedure, apply to some of the covered dental procedures listed in the attached dental fee schedule. Specific limits are set forth on the fee schedule, and are hereby incorporated by reference into the EOC.

Domiciliary care. Care for you if you are capable of caring for yourself; however, you must be maintained in a monitored environment for health maintenance and safety.

Drugs – Limitation

Note: In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with Health Plan emergency management department. By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. Kaiser Permanente Medicare Plus does not cover the following drugs and accessories:

- Drugs that are not covered by Medicare Part B or Part D unless otherwise noted in the EOC.
- Non-Formulary drugs and accessories that are not deemed medically necessary.
- Any formulations or alternative delivery methods for medications not deemed medically necessary are not covered.

- Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes.
- Dental prescriptions other than those prescribed for pain relief or antibiotics.
- Replacement prescriptions necessitated by theft or loss
- Prescribed drugs and accessories for services that are excluded under Kaiser Permanente Medicare Plus.
- All drugs and accessories for the sole purpose of foreign travel.
- Growth hormones.
- Inhalation therapies for treatment or prevention of viral infections.
- Inhaled insulin
- Drugs used for athletic performance, anti-aging, mental performance, hair growth, non-prescription contraceptive supplies and devices, and non-prescription over-the-counter drugs unless designated as part of a step therapy
- Special Packaging is not covered. Packaging of prescription medications is limited to Plan stated packaging.
- Benzodiazepines
- Barbiturates
- Drugs for anorexia
- Drugs for weight loss
- Drugs for weight gain
- Drugs used to promote fertility
- Drugs used for symptomatic relief of cough or colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparation products)
- Drugs for which the manufacturer seeks to require as a condition of purchase that associated tests and monitoring service be purchased exclusively from the manufacturer or its designee

Generally, Kaiser Permanente Medicare Plus does not cover medications you can buy without a prescription.

- Elective or voluntary enhancement procedures, services and supplies including but not limited to: sex change operations, weight loss - except as described in the EOC.
- Emergency facility services for non-authorized, routine conditions not based on an Emergency Medical Condition.
- Employer or Government Responsibility
 - a. Financial responsibility for services otherwise covered under this agreement for any illness, injury or condition to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"),

is provided under any workers' compensation or employers' liability law. We will provide services even if it is unclear whether a member is entitled to a Financial Benefit. However, we may recover the value, calculated at non-member rates, of any such services provided under the EOC, from any source providing a Financial Benefit or from whom a Financial Benefit is due. In the alternative, we may recover such value from the member to the extent that a Financial Benefit is provided or payable only if the member does not receive claim under workers' compensation or employers' liability law because of the member's failure to diligently seek to establish his or her rights thereto or if a financial benefit is actually received by the member.

- b. Financial responsibility for services that an employer is required by law to provide.
 - c. Services provided to veterans in Veteran's Affairs (VA) facilities. However, we will reimburse veterans for the cost-sharing for emergency services received at a VA hospital up to the amount that we charge for cost-sharing under Medicare Plus.
 - d. Financial responsibility for services for any illness, injury or condition when the law requires such service to be provided only by or received from a government agency.
- If there is a reasonable doubt whether any benefit is available or is required to be provided under any workers compensation or employers liability law, and if the member diligently seeks to establish his or her rights to benefits, then services that otherwise would be provided under the EOC will be provided. Except that the value of such services at non-member rates is recoverable by us or our nominee from any source providing benefits or from whom benefits are due, or from the member, to the extent that the monetary benefits are provided, or payable or would have been required to be provided if the member had diligently sought to establish his or her rights to such benefits. This provision does not apply to Medicaid benefits.
 - Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-qualifying clinical trial. Experimental procedures and items are those items and procedures determined by Kaiser Permanente and Original Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental, Kaiser Permanente will follow Medicare's manuals or will follow decisions already made by Medicare.

- Hearing aids and hearing examinations for prescribing, fitting or changing hearing aids, except for one hearing aid for each hearing impaired ear every 36 months for children through the age of 17 if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist.
- Homemaker services.
- Hospital and Skilled Nursing Facility services not covered include: a) charges for care and supplies not ordered by a Personal Physician or Plan Provider, if such care and supplies would not be paid for under Medicare guidelines; b) convenience and personal care items which are billed separately such as telephone, television or radio; c) private duty nurse; and, d) private room in a hospital, unless medically necessary.
- Independent medical examinations for the purpose of long-term disability.
- Infertility **Exclusions**
 - The cost of donor semen and donor eggs, including retrieval of eggs.
 - Storage and freezing of semen and eggs.
 - Gamete intrafallopian transfers (GIFT)
 - Zygote intrafallopian transfers (ZIFT).
- Infertility **Limitations**
 - Coverage for in-vitro fertilization is limited to three ⁽³⁾ attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000.
- Intermediate care, which is care provided in an intermediate care facility.
- Hypnotism or hypnotic anesthesia services are not covered.
- Services to reverse voluntary, surgically induced infertility.
- Meals delivered to your home.
- Nursing care on a full-time basis in your home.
- Orthopedic shoes and supportive devices for the feet. Except therapeutic shoes for those suffering from diabetic foot disease and orthopedic shoes that are part of a leg brace and are included in the orthopedist's charge.
- Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
- Private duty nurses.
- Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by Kaiser Permanente or covered by Medicare.
- Radial keratotomy and low vision aids and services.

- Routine foot care.
- Services that are not reasonable and necessary under Original Medicare guidelines.
- Services as a condition of probation, parole or any other third party court order unless a Plan Provider determines such services to be medically necessary and clinically appropriate.
- Surgical treatment of morbid obesity, except as described in the EOC.
- Treatment in a specialized alcoholism, drug abuse or drug addiction program treatment facility or program, when in the judgment of a Plan Provider, the Member has not been or would not be responsive to therapeutic management or has not been or is not motivated.
- The following Vision Care Services:
 - Sunglasses without corrective lenses unless medically necessary
 - Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism
 - Eye exercises
 - Cosmetic contact lenses
 - All services related to contact lenses including examinations, fittings and dispensing, and follow up visits, except as otherwise covered. Any contact lenses you require after we provide an initial pair of lenses may be purchased at a Kaiser Permanente Optical Shop on a fee-for-service basis.
 - Replacement of lost or broken lenses or frames
- Veteran Benefits which were provided through the Veterans Administration.